SECTION 11
SURGERY

PROCEDURE CODES

MO HealthNet recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a MO HealthNet reimbursement amount of $75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center, rural health clinic (RHC) or an office setting; and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, RHC, office, home, nursing home, etc.).

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 13 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery "incidentally" performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the MO HealthNet *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same participant on the same date of service by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in

coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

100% of the allowable fee for the major procedure
50% of the allowable fee for the secondary procedure
25% of the allowable fee for the third procedure

An operative report must always accompany claims with multiple surgical procedures on the same participant on the same date of service.

ASSISTANT SURGEON

MO HealthNet adheres to guidelines set by Medicare services for assistants at surgery.

Information on Medicare's guidelines for assistant surgeons is found in the Medicare Services Newsletter, "Indicators/Global Surgery Percentages/Endoscopies", at http://www.momedicare.com/provider/provnewslet/newsindex.asp. You must accept the **License for Use of "Physicians' Current Procedural Terminology", Fourth Edition (CPT)** agreement at this Web site before the information can be viewed. The indicator assigned to each surgical code is found in column A of the Surgery Indicator Table.

Examples found in Column A include:

- Some procedures do not require an assistant surgeon (Assistants at surgery are never paid for these procedures.)
- Assistant at surgery is paid (No payment restriction applies.)
- Payment restriction for assistants at surgery applies; a *Certificate of Medical Necessity* form is required (These procedures do not normally require an assistant surgeon but with medical necessity will be considered for payment.)

Note - Not all codes in the listing are covered by Missouri MO HealthNet; refer to the MO HealthNet fee schedule at **www.dss.mo.gov/mhd/providers/index.htm** for coverage information.

The medical necessity for the assistant at surgery must be fully documented on the C*ertificate of Medical Necessity* (CMN) form. The form must include the assistant surgeon's name, provider National Provider Identifier, and signature. Instructions for completing the *Certificate of Medical Necessity* form are in Section 7.2 of the Missouri MO HealthNet *Provider Manual.* The CMN form can also be submitted electronically through the MO HealthNet Internet billing Web site, emomed.com, as an attachment to the medical claim by clicking on the "Medical Necessity" link at right side of each line of the claim on the claim form.

CO-SURGERY

"Co-Surgeons" are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic MO HealthNet provider number. The surgical procedure code together with modifier "62" should be shown on both claims. The name of both surgeons must appear on the claim form in the "description" area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician, and advice or recommendations for patient treatment. When a consulting physician begins to "treat" rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service.

CONSULTATION CODES

Office/Outpatient Consult Codes	In-patient Consult Codes
99241	99251
99242	99252
99243	99253
99244	99254
99245 (requires a copy of the consult report with the claim)	99255 (requires a copy of the consult report with the claim)

SECOND SURGICAL OPINION

The intent of the Second Surgical Opinion Program is to provide an eligible Missouri MO HealthNet patient with a second opinion as to the medical necessity of certain elective surgical operations. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the MO HealthNet patient. A list of the procedure codes requiring a second surgical opinion appears later in this section.

The Second Surgical Opinion form can be submitted electronically through the MO HealthNet Internet billing Web site, emomed.com

The Second Surgical Opinion form contains four sections and must be completed in the following manner:

Section I This section is completed by the physician recommending surgery. The appointment date in this section must be the date the patient was seen by the physician recommending surgery.

Section II Completed by the second opinion physician. A second opinion must be obtained within **60 days** after the primary recommendation appointment date in Section I of the form. When rendering a second opinion, the physician should bill a procedure code in the range of 99271-99274.

Section III Completed by the third opinion physician. A third opinion must be obtained within **60 days** after the second opinion appointment date in Section II. A third opinion is allowed by Missouri MO HealthNet if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation. When rendering a third opinion, the physician should bill a procedure code from the range 99271-99274.

Section IV Completed by the surgeon. Surgery must be performed within **150 days** of the first appointment date in Section I. Section IV should be completed and signed by the surgeon any time on or after the date of surgery. It is the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed second opinion form.

Staff interns, residents, and nurse practioners are **not** permitted to provide the first, second, or third opinion.

Note – Anesthesiologists, assistant surgeons, independent laboratories, and independent x-ray services are exempt from the requirement to submit a copy of the Second Surgical Opinion form with a claim for services.

EXCEPTIONS TO SECOND OPINION REQUIREMENT

- Medicare/MO HealthNet crossover claims are exempt.
- The Second Surgical Opinion form is not required if the surgeon does not participate in the Missouri MO HealthNet Physician Program. This must be stated in field 19 of the CMS-1500 claim form and the physician's full name listed.
- Those surgical operations specified are exempt from the second surgical opinion requirement if any one of them is performed incidental to a more major surgical procedure that does not require a second surgical opinion.
- If the service was performed as an emergency and a second opinion could not be obtained prior to rendering the service, complete the claim form and enter "emergency" in field 19 of the CMS-1500. Attach a *Certificate of Medical Necessity* form (or other adequate documentation such as operative notes, admit or discharge summaries, etc.) to the claim. The provider must state on the *Certificate of Medical Necessity* form, in detail, the reason for the emergency provision of service.
- If the participant was not eligible for MO HealthNet at the time of service, but was

made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted with a completed *Certificate of Medical Necessity* form indicating the participant was not eligible at the time of service but has become eligible retroactively to that date. (See Section 7 of the MO HealthNet *Provider Manual* for information on completing the *Certificate of Medical Necessity* (CMN) form. The CMN form can also be submitted electronically through the MO HealthNet Internet billing Web site, emomed.com, as an attachment to the medical claim by clicking on the "Medical Necessity" link at right side of each line of the claim on the claim form.) If the eligibility approval letter or the *Certificate of Medical Necessity* form is not submitted, the claim will be denied.

SURGERY CODES THAT REQUIRE A SECOND OPINION

The following six procedure codes require the submission of either a paper or electronic *Second Surgical Opinion* form.

66840 - removal of lens material aspiration technique, one or more stages
66850 - removal of lens material phacofragmentation technique
66852 - removal of lens material; pars plana approach, with or without virectomy
66920 - removal of lens material; intracapsular
66983 - intracapsular cataract extraction with insertion of intraocular lens prosthesis- one stage procedure
66984 - extracapsular cataract removal with insert, intraocular lens prosthesis- one stage procedure, manual or mechanical technique.